Anesthesiology Leadership Rounding: Identifying Opportunities for Improvement

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Abstract

Introduction: Rounding that includes participation of individuals with authority to implement changes has been advocated as important to the transformation of an institution into a high-quality and safe organization. We describe a Department of Anesthesiology's experience with leadership rounding.

Methods: The Department Chair or other senior faculty designate, a quality coordinator, up to four residents, the ward charge nurse, and patient nurses participated in rounds at bedsides.

Results: During a 23-month period, 14 significant opportunities to improve care were identified. Nurses identified 5 of these opportunities, primary team physicians 2, the rounding team 4, and patients or their family members another 3. The anesthesiology service had sole or shared responsibility for 10 improvements.

Conclusion: A variety of organizations track specific measures across all phases of the patient experience to gauge quality of care. Chart auditing tools for detecting threats to safety are often used. These measures and tools missed opportunities for improvement that were discovered only through rounding. We conclude that the introduction of leadership rounding by an anesthesiology service can identify opportunities for improving quality that are not captured by conventional efforts.

Introduction

Leadership rounding has been touted as essential to a comprehensive program to improve quality. The Institute for Healthcare Improvement believes leadership rounding to be one of the key elements in engaging physicians and staff in meaningful efforts to improve health care delivery.[1] Most often, involvement at the chief executive, nursing, operating room staff, or medical officer level is described. Leadership rounding within a unit has been shown to reduce staff turnover rate and to have a positive influence on nurses' perceptions of the patient safety climate within the unit.[2,3] The Department of Anesthesiology at the University of Florida introduced leadership rounding at the level of the departmental chair to search for areas where delivery of care could be improved. These rounds led to a startling number of interventions both within the department and throughout many other units in our hospital. This is the first report of a Department of Anesthesiology using leadership rounding to improve quality.

Methods

Beginning in January 2010, the Chair of the Department of Anesthesiology assembled a multidisciplinary group to visit postsurgical patients and discuss opportunities for quality improvement with them, their families, nurses, and ancillary staff. Members of the leadership rounding team included the department chair, the departmental quality coordinator, two to four residents, the bedside nurse, and a ward manager. If the chair was not available, another senior faculty member led the team. The residents who joined the rounds were assigned to locations that did not have early clinical starts (eg, the postanesthesia care unit and preoperative evaluation clinic). Typically, rounding included up to five patients and occurred once every week. Patients were selected for rounding according to their surgery date (within three days), the unit they were on, and which anesthesiology personnel provided their care. This ensured that all patient care areas and faculty members would be reviewed.

A single interview form was used (Figure 1). In addition, a standard audit of the records related to the anesthesiologic management of each patient was also systematically checked. Any deficiencies found during the review of anesthesiology-related documentation (the preoperative evaluation, consent and time-out forms, the anesthesiology record, and the postoperative anesthesia evaluation) were recorded on the form. The postoperative anesthesia evaluation contains anesthesiology-specific questions that relate to the patient's (and patient's family's) perception of the quality of the anesthesia care they experienced (Table 1).

Additionally, the rounding team brought administrators face-to-face with patients, their families, and the nurses providing postoperative care. This allowed for impromptu observation of how the patient was convalescing, and for bedside discussions with the group about frustrations and successes. This open-interview component, led by the depart-

Table 1. Quality elements in a postoperative anesthesia evaluation note

Rate any sore throat[a]
Rate any pain[a]
Describe problems with nausea[a]
Dental, neural, and skin injuries
Last/first thing you recall before/after surgery?

[a]These items are also on the Patient Quality Rounds Interview Form.

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ment chair, encouraged family members and clinicians to comment on the hospital experience in the context of their value system and expectations, which may not have been captured by the questions on the form. These remarks were included in the comments section of the form. Finally, a note was sent to all the clinicians involved in each patient's care, informing them of the findings of the leadership rounds with their patient and whether those findings exceeded, met, or fell short of expectations. Recipients included department faculty, residents, anesthesiologists, nursing managers, and surgical or medical department chairs when appropriate. Furthermore, these letters were included in the annual evaluations of the involved departmental faculty. A sample letter is shown in Figure 2. Our clinical improvement coordinator followed-up issues identified on leadership rounds.

Patient Quality Rounds Interview Form

DOS	Patient:	MR:	Age:	Room:	DX:
Surgeon			**Procedure:**		
Anesthesia Providers:					
Pre OP					
Were you comfortable with care?					
Were you/family well informed?					
Were you/family made aware of time changes?					
Intra OP					
Recall					
Sore throat					
Post OP/ PACU					
Any problems with pain?					
Nausea					
Issues addressed timely					
Overall					
OR experience					
Anesthesia care					
Changes to improve satisfaction					
Anything unexpected					
Safety Check					
IS (demonstrate use)					
SCD (connected/on)					
Foley positioned correctly (applicable)					
Documentation					
Time-out Completed (signed, dated, timed, legible):					
POAE completed (within 48 hr) by:					
Consent					
Other: Improvements/Assignments					

Figure 1. Elements of rounding interview.

DOS = date of surgery; DX = diagnosis; IS = incentive spirometer; MR = medical record number; OP = operative; OR = operating room; PACU = postanesthesia care unit; POAE = postoperative anesthesia evaluation; SCD = sequential compression devices.

Date:
To:
RE:
MR:

Dear Dr (Name),

This is a note regarding a patient that you saw in the recovery room on (date), Mr (Name). As you may recall, Mr (Name) was a patient of Dr (Name)'s who underwent a (procedure). Postoperatively he did so well that he was able to be discharged rather than being admitted to the hospital. He was incredibly pleased with his anesthesia care, although he did have a small amount of nausea postoperatively.

As we perused his electronic medical record, we were unable to find the postoperative anesthesia note that should have been part of the discharging process. So I took the liberty of going ahead and making a note in his chart regarding that. I just wanted to make sure that you were aware of the fact that each patient is to have a postoperative discharge note.

Again, I appreciate your help in the care of this patient, who was very pleased with our services, and I hope that we can make electronic charting more user-friendly for all of us in the future.

Sincerely,

Professor and Chair
Department of Anesthesiology

Figure 2. The text of a postvisit letter sent to care team members (names and dates have been removed).

Results

Over 23 months, 14 significant opportunities for improving care were identified. Table 2 summarizes the cumulative accomplishments of the weekly rounds, which typically lasted 1 hour. Table 3 lists the opportunities for quality improvement that were identified during rounds, who identified the issues, and what actions were taken in response. Nursing staff identified 5 of these opportunities, primary team physicians 2, the rounding team 4, and patients and their family members another 3. The anesthesiology service had sole or shared responsibility for 10 improvements.

Corrective actions were implemented in a variety of ways to reach a wide circle of stakeholders. Education (development and standardization of best practice to secure arterial line, incentive spirometer use, dependent Foley placement, consistent sequential compression device use, and implementation of standardized signage across all units) was accomplished separately from the Chair's letter by means of e-mail distributed to the entire faculty, residents, and anesthesiologists. Additionally, findings and supportive literature were presented at quarterly departmental quality-improvement conferences and to hospital leadership at the Physicians' Quality and Safety Executive Committee.

The rounding team requested improvements requiring capital purchases (orthopedic stretcher chairs, pediatric cribs, and interchangeable monitors) through the Chief Quality and Chief Financial Officer and justified them with the discoveries made during rounds.

Table 2. Cumulative accomplishments of the rounding group between January 2010 and November 2011

Participants/outcomes	N
Patients interviewed	119
Residents participating	42
Faculty leaders	9
Intensive care units visited	7
Other surgical units	10
Procedure unit (MRI)	1
Quality improvement actions	14
Letters sent out by chair	75

MRI = Magnetic resonance imaging.

We made changes to procedures, protocols, processes, and forms (adoption of airway trays, perioperative pain control protocol, critical contact badge cards, serial consent forms, uniformity of instruction sheets across clinics, secure custody of patient valuables, facilitation of postoperative anesthesia evaluation, addition of incentive spirometry to anesthesia order set, and uniform transport policy). Participation of all stakeholders was required to develop these improvements. Approval from the Legal Department was obtained, and the final institutional Forms Committee ensured compliance with existing forms, policies, and procedures.

The improvements in education, equipment, forms, policies, procedures, and processes took months to complete but have effectively addressed the deficiencies and complaints they targeted.

Discussion

University Health System Consortium and Centers for Medicare and Medicaid Services have identified numerous, wide-ranging measures that it has linked to quality of care.[4,5] Performance across these measures is individually and collectively graded and compared to other institutions' performance and then reported on a scorecard. The Centers for Medicare and Medicaid Services enable

consumers to compare hospitals on this basis (www.hospitalcompare.hhs.gov). Designing an electronic medical record to capture those measures specified by regulatory agencies is straightforward. What this metric reporting approach lacks, however, is the ability to expose lapses of care or quality that fall outside of the specific areas mandated for reporting. Performance improvement is stifled if it is restricted to measures that can be easily quantified. Efforts guided by greater emphasis on the patient's service experience (eg, Hospital Consumer Assessments of Healthcare Providers and Systems[6]) can begin to address patient perceptions, and, conceivably, the quality of care they actually receive.

The postoperative patient and bedside nurse interviews that are an integral part of our quality rounds are valuable sources for identifying patient-centered opportunities for improving quality. The interviews provided a welcomed forum for nurses and other staff who interact with patients to provide insights on safety issues and ideas for improving the quality of anesthesia and institutional care.

One of the key motivations of the Chair for initiating these quality rounds was specifically to give anesthesiology residents a human context for the work they do. However, resident involvement in these rounds accrued many more benefits. Thus, we believe integration of resident physicians to be a key element of this project. Our graduate medical education office deemed resident physician involvement in these rounds a model of institutional commitment to a culture of improved safety and quality.

Despite a well-established, continual quality-improvement program, the addition of leadership rounding resulted in discovery of 14 significant opportunities for improving care over a 23-month period. Remarkably, bedside nursing staff identified 5 of these opportunities, primary team physicians 2, the rounding team 4, and patients and their family members another 3. The anesthesiology service had sole or shared responsibility for 10 improvements. This distribution of participants underscores the value of diversity in a rounding team, involvement of patients and their families, and participation of leaders who are able to follow through and effect the necessary improvements.

Conclusion

Use of a traditional method for assessing outcomes the Rounding Team can also identify opportunities for improving quality in anesthesia that are not captured by patient safety reports and not included in nationally reported quality metrics. Leadership rounding in anesthesiology can provide valuable metrics for inclusion in an electronic medical record, an audit for compliance with documentation, tangible evidence of leadership's commitment to quality, and feedback

Table 3. Opportunities for quality improvement identified during rounds

Observer	Observation	Response
N	Patients' legs elevated using nonstandard/unapproved methods	Addition of 18 orthopedic stretcher chairs
N	Delayed transportation of patients from OR to PICU because of a shortage of cribs	Facilitated availability of additional pediatric cribs
N	Nonuniform arterial line dressing: decannulation, deep tissue injury, immobility	Developed and standardized best practice to secure arterial line
N	Dissatisfaction with turnover time in burn unit OR	System to replace medication and airway trays
N	Inconsistent process for transferring patients with monitors to preoperative holding	All units have interchangeable monitors and a standardized transport process
MD	High rate of medication dependency at D/C for BICU patients	Developed and introduced perioperative pain control protocol
MD	Large phone list made calling correct individual difficult	Developed the Badge Buddy, with critical contact info
R	Untimely/illegible POAE	Developed processes to facilitate POAE completion for all patients
R	Reviewed incentive spirometer, Foley catheter, and sequential compression device	Educated nursing staff and patients about the value of compliance
R	Identified patients who were not provided incentive spirometer postoperatively	Incentive spirometer added to postoperative anesthesia order set
R	Signage mandated in SICU following TSRPT not used by PICU	Implemented consistent signage institutionwide
P/F	Concern about security of possessions during surgery	Nurse administrator developed secure custody system
P/F	Repeated patient/family complaints of being awakened after midnight for consent for each of a series of treatments	Developed and adopted an informed consent form for serial anesthetics
P/F	Conflicting versions of a preoperative information packet were in use	Developed and adopted a single preoperative instruction sheet (and process) for all clinics

BICU = burn intensive care unit; D/C = discharge; N = nursing staff; MD = physician involved with patient care; OR = operating room; P/F = patient or family member; PICU = pediatric intensive care unit; POAE = postoperative anesthesia evaluation; R = rounding team; SICU = surgical intensive care unit; TSRPT = transsphenoidal resection of pituitary tumor.

to clinicians on their performance. Leadership rounding has the potential to uncover lapses of care that may otherwise have remained invisible to even robust quality-improvement systems. ❖

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Doing Things

Management is doing things right;
leadership is doing the right things.

— Peter Drucker, 1909-2005, Austrian-born American management consultant, educator, and author